

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
HEALTH AND RECOVERY SERVICES ADMINISTRATION  
Olympia, Washington**

**To:** Resource Based Relative Value  
Scale (RBRVS) Users:  
Anesthesiologists  
Advanced Registered Nurse  
Practitioners  
Emergency Physicians  
Family Planning Clinics  
Federally Qualified Health Centers  
Health Departments  
Laboratories  
Managed Care Plans  
Nurse Anesthetists  
Ophthalmologists  
Physicians  
Physician Clinics  
Podiatrists  
Psychiatrists  
Radiologists  
Registered Nurse First Assistants

**Memorandum No: 05-125 MAA  
Issued: December 29, 2005**

**For Information Call:  
1-800-562-3022**

**From:** Douglas Porter, Assistant Secretary  
Medical Assistance Administration (HRSA)

**Subject: Physician-Related Services: 2006 Changes and Additions to CPT™ and HCPCS  
Codes, Policies and Fee Schedules**

**Effective for dates of service on and after January 1, 2006, the Health and Recovery  
Services Administration (HRSA) will:**

- Begin using the Year 2006 Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) Level II code additions as discussed in this memorandum;
- Update the Physician-Related Services Fee Schedule to include the new 2006 codes, fees, and base anesthesia units (BAU); and
- Update and clarify various policies and payment rates.

\* HCPCS – Healthcare Common Procedure Coding System.

## Overview

- **All policies previously published remain the same unless specifically identified as changed in this memo.**
- The new 2006 additions and deletions are available on the HRSA Fee Schedules web page. Visit our website at <http://maa.dshs.wa.gov>. Click on Provider Publications/Fee Schedules, then Fee Schedules.
- Do not use CPT and HCPCS codes that are deleted in the “*Year 2006 CPT*” book and the “*Year 2006 HCPCS*” book for dates of service after December 31, 2005.

## Maximum Allowable Fees and BAU

HRSA used the following resources in determining the maximum allowable fees and BAU for the Year 2006 additions:

- Year 2006 Medicare Physician Fee Schedule Data Base (MPFSDB) relative value units;
- Year 2006 Washington State Medicare Laboratory Fee Schedule; and
- Current Conversion Factors.

**Note:** Due to its licensing agreement with the American Medical Association regarding the use of CPT codes and descriptions, HRSA publishes only the official brief description for all codes. Please refer to your current CPT book for full descriptions.

## Deleted CPT and HCPCS Modifiers

The Centers for Medicare and Medicaid Services (CMS) deleted HCPCS modifier **QB**, **QQ**, and **QU** from the 2006 HCPCS book.

## New 2006 HCPCS Modifiers

Many new modifiers were added in the 2006 HCPCS book. HRSA accepts all of these modifiers as informational only. Modifier descriptions may be viewed in the 2006 HCPCS book. HRSA may require inclusion of some of the modifiers for payment purposes. HRSA will notify you in future memorandums when a modifier is required for payment purposes.

## Deleted CPT and HCPCS Codes

Effective for dates of service on and after January 1, 2006, HRSA no longer pays for the following codes since they are deleted from the current CPT or HCPCS book:

0010T	78170	97520	G0030	G0349	Q2014
0020T	78172	97703	G0031	G0350	Q2018
0023T	78455	99052	G0032	G0351	Q2019
0033T	82273	99054	G0033	G0353	Q2020
0034T	83715	99141	G0034	G0354	Q2021
0035T	83716	99142	G0035	G0355	Q2022
0036T	86064	99261	G0036	G0356	Q3000
0037T	86379	99262	G0037	G0357	Q3002
0038T	86585	99263	G0038	G0358	Q3003
0039T	86587	99271	G0039	G0359	Q3004
0040T	90780	99272	G0040	G0360	Q3005
01964	90781	99273	G0041	G0361	Q3006
15342	90782	99274	G0224	G0362	Q3007
15343	90783	99275	G0225	G0363	Q3008
15350	90784	99301	G0226	J0880	Q3009
15351	90788	99302	G0227	J1563	Q3010
15810	90799	99303	G0228	J1564	Q3011
15811	90871	99311	G0229	J1750	Q3012
16010	90939	99312	G0230	J2324	Q4054
16015	92330	99313	G0231	J7051	Q4055
21493	92335	99321	G0232	J7317	Q4075
21494	92390	99322	G0233	J7320	Q4076
31585	92391	99323	G0234	J7616	Q4077
31586	92392	99331	G0242	J7617	Q9941
32520	92393	99332	G0244	K0628	Q9942
32522	92395	99333	G0252	K0629	Q9943
32525	92396	A4643	G0253	L8620	Q9944
33918	92510	A4644	G0254	Q0136	S0071
33919	95858	A4645	G0258	Q0137	S0072
37720	96100	A4646	G0263	Q0187	S0107
37730	96115	A4647	G0264	Q1001	S0114
42325	96117	A9511	G0279	Q1002	S0118
42326	96400	A9513	G0280	Q2001	S0158
43638	96408	A9514	G0296	Q2002	S0159
43639	96410	A9515	G0330	Q2003	S0168
44200	96412	A9519	G0331	Q2005	S0173
44201	96414	A9520	G0336	Q2006	S2082
44239	96520	A9522	G0338	Q2007	
69410	96530	A9523	G0345	Q2008	
76375	96545	A9525	G0346	Q2011	
78160	97020	A9533	G0347	Q2012	
78162	97504	A9534	G0348	Q2013	

## Prior Authorization Update

The following CPT and HCPCS codes require prior authorization (PA) (list includes both new 2006 codes and existing codes with requirement changes):

0120T	33886	90734
0123T	33889	90779
0124T	36470	92626
0126T	36471	92627
0137T	43770	92630
0140T	43771	92633
0141T	43772	95251
0142T	43773	95873
0143T	43774	95874
0144T	43845	96101
0145T	43886	96116
0146T	43887	96118
0147T	43888	99183
0148T	46505	99318
0149T	64650	99339
0150T	64653	99340
0151T	69930	A9542
0152T	78814	A9543
0153T	78815	A9544
0154T	78816	A9545
15170	83037	A9552
15171	83900	A9698
15175	83907	G0378
15176	83908	J7341
15340	83909	L8623
15341	83914	L8624
15360	86480	Q9955
15361	88333	Q9956
15365	88334	Q9957
15366	88380	S0265
33880	88384	S2900
33881	88385	S3626
33883	88386	S3854
33884	90733	

\*For Details on HRSA's PA process, refer to the Authorization section (Section I) of HRSA's current *Physician-Related Billing Instructions*.

## New Expedited Prior Authorization Criteria

The procedures on the following pages require expedited prior authorization (EPA). Please refer to the authorization section of your billing instructions for information on how to create an EPA number. If EPA criteria can not be met and there is strong evidence of medical necessity, you have the option of submitting a written/fax authorization request (see Section I of HRSA's current *Physician-Related Billing instructions* for details).

### Cochlear Implants

**CPT:** 69930

**HCPCS:** L8615-L8618, L8621-L8624

**Dx.:** 389.10-389.18

423 When **one** of the following is true:

- 1) **Unilateral cochlear implantation** for adults (age 18 and older) with post-lingual hearing loss and children (age 12 months-17 years) with prelingual hearing loss when all of the following are true:
  - a) The client has a diagnosis of profound to severe bilateral, sensorineural hearing loss;
  - b) The client has stimuable auditory nerves but has limited benefit from appropriately fitted hearing aids (e.g., fail to meet age-appropriate auditory milestones in the best-aided condition for young children, or score of less than ten or equal to 40% correct in the best-aided condition on recorded open-set sentence recognition tests;
  - c) The client has the cognitive ability to use auditory clues;
  - d) The client is willing to undergo an extensive rehabilitation program;
  - e) There is an accessible cochlear lumen that is structurally suitable for cochlear implantation;
  - f) Client does not have lesions in the auditory nerve and/or acoustic areas of the central nervous system; and
  - g) There are no other contraindications to surgery; **or**
- 2) **Replacement Parts for Cochlear Implants** when all of the following are true:
  - a) HRSA has purchased the implant(s);
  - b) The manufacturer's warranty has expired;
  - c) The part is for immediate use, not a back-up part; and

- d) The part is not an external speech processor (these require written/fax authorization).

**Please Note:** Effective for dates of service on and after January 1, 2006, HCPCS code L8619 requires PA.

### Hyperbaric Oxygen Therapy

**CPT: 99183**

425 When both of the following are true:

- 1) The diagnosis is 250.70-250.83; and
- 2) Hyperbaric Oxygen Therapy is being done in combination with conventional diabetic wound care.

### Meningococcal Vaccine

**CPT: 90734 (Conjugate Vaccine – Menactra®)**

421 Client is 11 years of age through 55 years of age and meets in one of the “at risk” groups because the client has one of the following:

- 1) Has terminal complement component deficiencies;
- 2) Has anatomic or functional asplenia;
- 3) Is a microbiologist who is routinely exposed to isolates of N. meningitidis; or
- 4) Is a freshman entering college who will live in a dormitory.

**CPT: 90733 (Polysaccharide vaccine – Menomune®)**

424 Client meets at least 1 of the 4 criteria for use of the meningococcal vaccine outlined for EPA code 421 (CPT code 90734) and **one of the following is true:**

- 1) The client is one of the following:
  - a) 2 years of age through 10 years of age; or
  - b) Older than 55 years of age.
- 2) The conjugate vaccine is not available.

## Chemotherapy Administration

For dates of service on and after January 1, 2006, HRSA is updating the chemotherapy administration policy as follows:

- You may bill chemotherapy administration (CPT codes 96409 or 96411) for each drug administered.
- HRSA pays for only one “initial” drug administration code (CPT code 96409 or 96413) per encounter unless:
  - ✓ Protocol requires you to use two separate IV sites; or
  - ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second “initial” service code with modifier -59.
- HRSA does not pay for CPT code 99211 on the same date of service as the following drug administration codes: 96401-96549. If billed in combination with one of these drug administration codes, HRSA will deny the Evaluation and Management (E&M) code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable E&M service was provided. If you do not use modifier 25, HRSA will deny the E&M code.
- **Items and Services Not Separately Payable with Drug Administration:**  
Some items and services are included in the payment for the drug administration service, and HRSA does not pay separately for them. These services include, but are not limited to:
  - ✓ The use of local anesthesia;
  - ✓ IV start;
  - ✓ Access to indwelling IV (a subcutaneous catheter or port);
  - ✓ A flush at conclusion of an infusion;
  - ✓ Standard tubing; and
  - ✓ Syringes and supplies.
- **Infusion v. Push:**  
An intravenous or intra-arterial push is defined as:
  - ✓ An injection in which the health care professional who administers the substance or drug is continuously present to administer the injection and observe the patient;  
OR
  - ✓ An infusion of 15 minutes or less.

## Injectable Drug Updates

HRSA is updating the Injectable Drug Fee Schedule for January 1, 2006. You may access this at <http://maa.dshs.wa.gov>. Click on Provider Publications/Fee Schedules, and then click on Fee Schedules

## Therapeutic or Diagnostic Injections (CPT codes 90760-90779)

For dates of service on and after January 1, 2006, HRSA is updating the Therapeutic Injections section as follows:

- If no other service is performed on the same day, you may bill a subcutaneous or intramuscular injection code (CPT code 90772) in addition to an injectable drug code.
- HRSA does not pay separately for these injections if they are provided in conjunction with IV infusion therapy services (CPT codes 90760, 90761, and 90765-90767).
- HRSA pays for only one “initial” intravenous infusion code (CPT codes 90760, 90765, and 90774) per encounter unless:
  - ✓ Protocol requires you to use two separate IV sites; or
  - ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second “initial” service code with modifier 59.
- HRSA does not pay for CPT code 99211 on the same date of service as drug administration CPT codes 90760-90761, 90765-90768, or 90772-90779. If billed in combination, HRSA denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, HRSA will deny the E&M code.
- **Concurrent Infusion:** HRSA pays for concurrent infusion (CPT code 90768) only once per day.



## **Sandostatin**

Effective January 1, 2006, HRSA no longer requires PA for HCPCS codes J2353 and J2354.

## **STAT Laboratory Services**

You may bill the following additional CPT codes for STAT lab services: 86367 and 86923.

## **Immune Globulin Reminder**

Bill for immune globulin injections using the appropriate HCPCS code. HRSA does not pay for immune globulins billed with CPT codes (e.g., HRSA does not pay for CPT code 90283 but does pay for HCPCS codes J1566 and J1567).

## **Immunizations billed with the SL modifier**

When billing HRSA for an immunization that is available free-of-charge from the Department of Health (DOH), you must include both of the following:

- The appropriate procedure code for the vaccine given; and
- The SL modifier (**For example:** 90707 SL).

**Effective for claims with dates of service on and after August 1, 2005, HRSA pays \$5.90 for the SL modifier billed with vaccines obtained free from DOH.**

## Immunization Administration Grid

The following grid, found on page C.9 of HRSA's current *Physician-Related Services Billing Instructions*, was missing administration codes 90471 and 90472 when HRSA published Numbered Memorandum 05-43 MAA. Below is the complete grid which includes those administration codes. These codes may be used when billing vaccines that are **not** available free-of-charge from DOH. See page C.11 of HRSA's current *Physician-Related Services Billing Instructions*.

Procedure Code	Brief Description	Non-Facility Fee	Facility Fee
90465	Immune admin 1 inj, <8 yrs	\$11.13	\$11.13
90466	Immune admin addl inj, < 8 yrs	6.59	6.59
90467	Immune admin O or N < 8 yrs	5.05	5.05
90468	Immune admin O/N, addl < 8 y	3.03	3.03
90471	Immunization admin	*11.13	*11.13
90472	Immunization admin, each add	*6.59	*6.59

\* Fee is effective for dates of service on and after August 1, 2005.

### Please note:

- Do not bill CPT codes 90465-90468 in combination with CPT codes 90471-90472.
- For those drugs **not** available free-of-charge from DOH, HRSA pays an immunization administration fee for a maximum of two vaccines.

### For example:

- ✓ One unit of 90465 and one unit of 90466;
- ✓ One unit of 90467 and one unit of 90468; or
- ✓ One unit of 90471 and one unit of 90472.

## Immunizations Available from Department of Health

HRSA updated the immunization grid beginning on page C.11 of HRSA's current *Physician-Related Services Billing Instructions* to properly reflect which immunizations are available free-of-charge from DOH. This information is in the table below and will be incorporated in the July *Physician-Related Services Billing Instructions*.

Vaccines that are **shaded** in the table are available free-of-charge from DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children age 18 years and younger. **HRSA does not pay for these vaccines.**

CPT	Vaccine	CPT	Vaccine
90585	Bcg vaccine, percut	90704	Mumps vaccine, sc
90586	Bcg vaccine, intravesical	90705	Measles vaccine, sc
90632	Hep a vaccine, adult im	90706	Rubella vaccine, sc
90633	Hep a vacc, ped/adol, 2 dose	90707	Mmr vaccine, sc
90636	Hep a/Hep B vacc (adult)	90708	Measles-rubella vaccine, sc
90645	Hib vaccine, hboc, im	90712	Oral poliovirus vaccine
90646	Hib vaccine, prp-d, im	90713	Poliovirus, ipv, sc
90647	Hib vaccine, prp-omp, im	90714	Td vaccine no prsrv>=7im
90648	Hib vaccine, prp-t, im	90715	Tdap, 7 years and older, intramuscular
90655	Flu vacc split pres free 6-35 months	90716	Chicken pox vaccine, sc
90656	Flu vacc split pres free 3 years and above	90717	Yellow fever vaccine, sc
90657	Flu vaccine, 6-35 mo, im	90718	Td vaccine >7, im
90658	Flu vaccine, 3 yrs, im	90720	Dtp/hib vaccine, im
90660	Flu vacc, nasal (Covered October 1 through March 31 only)	90725	Cholera vaccine, injectable
90665	Lyme disease vaccine, im	90732	Pneumococcal vacc, adult/ill
90669	Pneumococcal vacc, ped<5	90733	Meningococcal vaccine, sc
90675	Rabies vaccine, im	90734	Meningococcal vacc,intramuscular
90676	Rabies vaccine, id	90735	Encephalitis, vaccine, sc
90690	Typhoid vaccine, oral	90740	Hepb vacc, ill pat 3 dose im
90691	Typhoid vaccine, im	90743	Hep b vacc, adol, 2 dose, im
90692	Typhoid vaccine, h-p, sc/id	90744	Hep b vacc ped/adol 3 dose, im
90700	Dtap vaccine, im	90746	Hep b vaccine, adult, im
90701	Dtp vaccine, im	90747	Hep b vacc, ill pat 4 dose, im
90702	Dt vaccine <7, im	90748	Hep b/hib vaccine, im
90703	Tetanus vaccine, im	90749	Vaccine toxoid

*Due to its licensing agreement with the American Medical Association, HRSA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.*

## Global (Total) Obstetrical (OB) Care

Global OB care (CPT codes 59400, 59510, 59610, or 59618) includes all the following:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

When more than one provider in the same clinic (same group provider number) sees the same client for global maternity care, HRSA only pays one provider for the global (total) obstetrical care.

Providers who are in the same clinic who **do not** have the same group provider number **must not** bill HRSA the global (total) obstetrical care procedure codes. In this case, you must "unbundle" the OB services and bill the antepartum, delivery, or postpartum care separately.

## High-Risk Additional Monitoring Modifier

HRSA changed the required modifier used when billing E&M codes for additional monitoring visits for high-risk conditions billed in **excess** of the normal antepartum guidelines. Providers who bill claims for high-risk additional monitoring visits for pregnancy-related services must attach the following modifier to the additional visit codes:

Modifier	Description
SK	High Risk Population

Refer to Section F of HRSA's current *Physician-Related Services Billing Instructions* for detailed guidelines regarding billing for maternity services.

**Note:** You must continue to use modifier TH when billing office visit codes 99201 - 99215 for antepartum care when you see the client for **only** 1-3 antepartum visits.

## Maternity Anesthesia Policy Clarification

When a physician starts a planned vaginal delivery (CPT code 01697) and it results in a cesarean delivery (CPT code 01968), both of these procedures may be billed. However, if both an anesthesiologist and a certified registered nurse assistant (CRNA) are involved, each provider bills only for those services he/she performed. The sum of the payments for each procedure will not exceed HRSA's maximum allowable fee.

## Smoking Cessation for Pregnant Women

**Effective for dates of service on and after January 1, 2006**, you must use the following new HCPCS procedure codes to bill for smoking cessation for pregnant women. For dates of service prior to January 1, 2006, you must use the CPT codes (see below) to bill for this service.

CPT Procedure Code	ICD-9-CM Diagnosis Codes	New HCPCS Code	January 1, 2006 Maximum Allowable Fee	
			Non Facility Setting	Facility Setting
99401	648.43 and 648.44	G0375 (Smoke/Tobacco Counseling 3-10)	\$15.26	\$15.03
99402		G0376 (Smoke/Tobacco Counseling >10)	30.23	29.78

## Irrigation of Venous Access Pump (CPT code 96523)

CPT code 96523 may be billed as a stand-alone procedure. However, if billed on the same day as an office visit, you must use modifier 25 to report a separately identifiable medical service. If you do not use modifier 25, HRSA will deny the E&M code.

## PET Scan Policy

**Retroactive to January 1, 2005**, you may bill PET scan CPT codes 78814-77816. A list of CPT codes allowed for PET scans is on the top of page I.11 of HRSA's current *Physician-Related Services Billing Instructions*. HRSA will update these billing instructions in the near future. Until then, make note of the addition of CPT codes 78814-77816 and the deletion of procedure codes G0330 and G0331 (which are currently on the list).

## Radiopharmaceutical Agents

HRSA incorrectly listed CPT code **79905** in the PA table on the top of page 4 in numbered memorandum 05-59 MAA. The correct procedure code is **79005**.

## Physical Therapy

**Effective for dates of service on and after January 1, 2006**, the following CPT codes are deleted: 97020, 97504, 97520, and 97703.

**Effective for dates of service on and after January 1, 2006**, the following CPT codes are added or revised: 97024, 97760, 97761, and 97762.

Procedure Codes	Brief Description	January 1, 2006 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97024*	Diathermy treatment	\$3.18	\$3.18
97760	Orthotic mgmt and training	18.62	15.44
97761	Prosthetic training	17.03	14.99
97762	C/O for orthotic/prosth use	15.67	10.45

## Sleep Studies and Approved Center of Excellence

HRSA limits payment for sleep studies to clients with diagnosis of obstructive sleep apnea or narcolepsy. For dates of service on and after October 1, 2005, the diagnosis range has been expanded to include the following: 327.21; 327.23; 327.26; and 327.27.

HRSA has added North Olympic Sleep Center, Silverdale, WA to the list of Approved Sleep Centers.

## Vagus Nerve Stimulation (VNS)

HRSA does not pay for Vagus Nerve Stimulation (VNS) programming CPT codes 95970, 95974, or 95975 or other VNS-related procedures (i.e., 64550-64565 or 64590-64595) when used to treat depression.

\*Denotes CPT Code description change ONLY.

## **How do I conduct business electronically with HRSA?**

You may conduct business electronically with HRSA by accessing WAMedWeb at <http://wamedweb.acs-inc.com>

## **How can I get HRSA's provider documents?**

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at <http://hrsa.dshs.wa.gov> (click *the Billing Instructions and Numbered Memorandum* link). These may be downloaded and printed.